# Application for CSHN Financial Assistance

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|---|
| Patient ID#: |
| Household ID#: |
| Clinic Type: |

**Please provide Patient and Parent Information requested below.**

| Child/Patient's Name | | | | | |
|---|---|---|---|---|---|
| | Last Name | First Name | Middle Initial | Date of Birth | Social Security Number |

Parent's Name(s): _____ Telephone: _____

| Mailing Address | | | | |
|---|---|---|---|---|
| | Street or Box Number | City/Town | State | ZIP |

**Instructions for remainder of the application:**

- All families are asked to complete item 1.
- If the CSHN patient has Medicaid/Dr. Dynasaur coverage, only items 1 and 5 need to be completed.
- Families without Medicaid/Dr. Dynasaur coverage who wish to apply for CSHN Financial Assistance should complete the entire application. (Items 1-5).
- Families who DO NOT WISH TO APPLY FOR CSHN FINANCIAL ASSISTANCE AT THIS TIME are requested to complete items 1, 2 and 5.
- The application is continued on the back of this sheet.

**1. Does the patient have Medicaid or Dr. Dynasaur coverage at this time? (Please check YES or NO.)**

| | | |
|---|---|---|
| | **YES** | We have Medicaid/Dr. Dynasaur coverage. We understand that we should notify CSHN at once if coverage changes.<br><br>CSHN will cover after-insurance balances for services authorized by CSHN but not covered by Medicaid/Dr. Dynasaur.<br><br>**If you answered YES to this question, you may simply sign the back of the application and return it to CSHN.** |
| | **NO** | We do not have Medicaid or Dr. Dynasaur coverage.<br><br>**Please go on to Item 2.** |

**2. Do you wish to apply for CSHN Financial Assistance? (Please check YES or NO.)**

| | | |
|---|---|---|
| | YES | Yes, we wish to apply for CSHN Financial Assistance. (Please go on to Item 3.) |
| | NO | No, we do not wish to apply for CSHN Financial Assistance at this time. We understand that we may attend CSHN clinics but that we (and our medical insurance) will be responsible for the cost of tests, treatment, supplies, medications, equipment and other services that may be authorized at clinic. We also understand that we may change our mind and apply for assistance at any time in the future. In the event that we apply later on, we understand that coverage is NOT retroactive. |

## *Application for CSHN Financial Assistance, Continued…*

3. **Household Income. (This item is required for families who are applying for Financial Assistance.)**

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|---|---|---|
| Annual Income: | Please report *Adjusted Gross Income* from your most recent federal Income Tax form. | **$** |

| | | |
|---|---|---|
| OR… | You may calculate your family income by using the worksheet, below. Please check the box at the right if you use the worksheet. | |

**Family Income Worksheet**

| **Type of Income** | **Who received Income?** | **Gross Amount** | **Payment period (weekly, monthly, annually, etc.)** | This space for CSHN use only. |
|---|---|---|---|---|
| Wages | | | | |
| | | | | |
| | | | | |
| Unemployment Insurance | | | | |
| Other (specify) | | | | |
| | | | | |

4. **Family Size: (Please complete the Family Size worksheet, below. All families applying for CSHN Financial Assistance are requested to complete this item.)**

| **Family Member** | | | **Number** |
|---|---|---|---|
| Yourself | | Enter **1** ⇒ | |
| Spouse | Enter "1" if married or if you are counting an unmarried partner whose income you reported in item 3. | ⇒ | |
| Child(ren) under age 21 | Enter number of children at home or, if living away from home, those whom you still claim as dependents. | ⇒ | |
| Others | Enter number of other people for whom you are financially responsible AND whom you claim as a dependent for tax purposes. | ⇒ | |

**5. Certification: The information I have provided is accurate to the best of my knowledge. I will provide reasonable verification if requested by CSHN.**

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Signature Date